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### Abortion and conscientious objection

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## Abortion and Conscientious Objection: *Doogan* – A Missed Opportunity for an Instructive Rights-Based Analysis

**Abstract:** Abortion is considered by some to be a morally questionable intervention, one which entitles the healthcare provider to exercise conscientious objection so as to opt out of acting. The healthcare provider's right to do so was recently considered by the UK Supreme Court in *Greater Glasgow Health Board v Doogan & Wood*, a case which set some boundaries on conscientious objection but which failed to engage holistically with the foundation of conscientious objection and its position relative to the competing right to adequate healthcare, a failure which must be seen as a lost opportunity given the manifold threats to timely access to abortion. This paper fills the lacunae. After noting the weaknesses in the *Doogan* judgment, it justifies the adoption of a more robust approach by the UKSC, and then analyses the moral and rights foundations of abortion and conscientious objection, noticing as it does the growing practical problem that is the expansion and misuse of conscientious objection in women's health (i.e., its deployment as a barrier to women seeking lawful abortion services). It concludes that courts everywhere, but particularly in jurisdictions that are widely persuasive, such as the UK, when faced with the opportunity to pronounce on the right to abortion and the operation of conscientious objection, should take full advantage, and in doing so should adopt a critical and restrictive approach to its availability in the healthcare context.

### I. Introduction

In a healthcare setting characterised by increasingly powerful interventions capable of both facilitating and interfering with the very early and very late stages of human life – stages that have traditionally been viewed as the bailiwick of Nature or God – a plurality of positions, and so some degree of moral conflict, is perhaps to be expected. Like contraception, enforced sterilisation, medically assisted conception, withdrawal of care, and assisted suicide, abortion is one such intervention; it has implications for the continued development of embryos and fetuses (potential persons), for the health, wellbeing, access to safe and effective healthcare, and life possibilities of pregnant women (rights-bearing persons-in-being), and for the personal and professional position of healthcare providers (moral agents in a unique calling), and it has been at the centre of political storms around the world for a long time.

Historically, the combination of religious characterisations of abortion as sin, a (male) gendered approach to reproductive rights and entitlements, and ongoing efforts by empowered elites to preserve socio-political control over others caused abortion to be managed through the criminal law. In the UK, abortion became a statutory crime under *Lord Ellenborough's Act 1803*.<sup>1</sup> It remained under the criminal law until the adoption of the *Abortion Act 1967* (1967 Act),<sup>2</sup> which made lawful the participation in abortion by certain individuals under certain conditions. Another example is Canada, wherein the provision of information about, or the means of securing, contraception was characterised as a 'crime against morality' until 1969, and where abortion remained under the *Criminal Code of Canada* (CCC)<sup>3</sup> until 1988. So situated, the (medical) practice of surgically – and now medically – terminating unwanted pregnancies has suffered a long, loud,

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<sup>1</sup> 43 Geo.III c. 58. For more on the history of abortion and its regulation in the UK: S Gavigan, 'The Criminal Sanction as it Relates to Human Reproduction: The Genesis of the Statutory Prohibition of Abortion' (1984) 5 J Legal History 20-43; S Sheldon, *Beyond Control: Medical Power and Abortion Control* (Pluto Press, 1997); S McGuinness and M Thomson, 'Medicine and Abortion Law: Complicating the Reforming Profession' (2015) 23 Med Law Rev 177-199.

<sup>2</sup> 1967 c. 87. The 1967 Act applies to England, Wales and Scotland, but not to Northern Ireland.

<sup>3</sup> RSC 1985, c. C-46.

vociferous, and lamentably violent history.<sup>4</sup> And despite waves of modernisation in the governance of abortion, largely as a result of the slow recognition of human rights and of women's reproductive rights, abortion remains within the ambit of the criminal law in many countries,<sup>5</sup> many of which impose quite restrictive abortion practices.<sup>6</sup>

In jurisdictions where abortion is authorised, healthcareers often have the potential to opt out of participating in treatment by raising a 'conscientious objection' (CO). Such a right is contained in s 4(1) of the 1967 Act, which states that no person is under a duty to participate in any treatment authorised by the Act to which he has a CO, though it is the objector's responsibility in any legal proceedings to prove the CO.<sup>7</sup> CO was most recently considered in *Greater Glasgow Health Board v Doogan & Wood (Doogan)*,<sup>8</sup> wherein two Roman Catholic midwives who served as Labour Ward coordinators at the Southern General Hospital objected to taking part in any aspect of the intervention that resulted in the termination of a pregnancy because they believed, in keeping with current Church dogma, that life begins at conception.<sup>9</sup> The case passed from the Outer House of the Court of Session, to the Inner House of the Court of Session, and then to the Supreme Court of the United Kingdom (UKSC), for which Lady Hale, for the Court, Lords Wilson, Reed, Hughes and Hodge concurring, stated that the only question before the Court was the meaning of the term 'to participate in any treatment authorised by this Act'.<sup>10</sup> She thus approached the case as a straight matter of statutory construction with some minimal reference to the social mischief that the 1967

<sup>4</sup> Women in many jurisdictions have been harassed and intimidated upon entering abortion facilities, physicians have been threatened, assaulted, and murdered, and facilities have been burned and bombed, a campaign which has been particularly acute in North America: D Blanchard and T Prewitt, *Religious Violence and Abortion* (U Press Florida, 1993); E Schaff, 'Redefining Violence against Women: The Campaign of Violence and the Delay of RU486' (1999) 8 Temple Pol Civil Rights Law Rev 311-324; National Abortion Federation, *Violence Statistics and History*, at <http://prochoice.org/education-and-advocacy/violence/violence-statistics-and-history/> [accessed 29 April 2016]. And see the range of stories on The Huffington Post's *Anti Abortion Violence* page, at <http://www.huffingtonpost.com/news/anti-abortion-violence/> [accessed 29 April 2016]. In Canada, a substantial body of jurisprudence addresses the management of 'zones of protection' around abortion facilities: *Ontario (AG) v Dieleman* (1994) 117 DLR (4th) 449 (Ont SC); *R v Watson and Spratt* (2006) 70 WCB (2d) 995 (BCCA); *R v Spratt* [2011] BCSC 1747; *R v Von Dehn* [2013] BCCA 187.

<sup>5</sup> R Cook and B Dickens, 'Human Rights Dynamics of Abortion Law Reform' (2003) 25 HR Quart. 1-59.

<sup>6</sup> Consider Ireland: R Fletcher, 'Contesting the Cruel Treatment of Abortion-Seeking Women' (2014) 22 Repro Health Matters 10-21. See WHO-Guttmacher Institute, *Facts on Induced Abortion Worldwide* (2012), at [http://www.who.int/reproductivehealth/publications/unsafe\\_abortion/induced\\_abortion\\_2012.pdf?ua=1](http://www.who.int/reproductivehealth/publications/unsafe_abortion/induced_abortion_2012.pdf?ua=1) [accessed 15 August 2016], which reports that unsafe abortions are still common.

<sup>7</sup> Subsection 4(2) makes clear that a CO does not absolve the individual from participating in treatment which is necessary to save the life, or to prevent grave permanent injury to the physical or mental health, of a pregnant woman. Subsection 4(3) states that, in Scotland, a statement under oath by the individual to the effect that he has a CO to participating in treatment authorised by the Act is sufficient to discharge the burden of proof.

<sup>8</sup> [2015] 1 AC 640 (UKSC), (2015) 142 BMLR 1 (UKSC).

<sup>9</sup> For centuries, the Catholic Church considered ensoulment to occur as a staged process, with 'personhood' commencing at quickening – 40 to 90-days post-conception – but this was moved forward to conception in the early 1700s. Though there was already a feast for Mary's birthday, a celebration day was also sought for her date of conception by those advancing the dogma of Immaculate Conception. Rather than choose the date of ensoulment supported by long-standing canon law (approximately six months pre-birth), Pope Clement XI, in 1708, chose December 8 (nine months pre-birth). Then, in 1854, Pope Pius IX proclaimed the dogma of Immaculate Conception and thereby established the doctrine of immediate animation. Thereafter, in 1869, he removed from canon law the distinction between an ensouled and un-ensouled foetus. For more on this metaphysical discussion and the politics behind it: C Bouman, 'The Immaculate Conception in the Liturgy', in E O'Connor (ed.), *The Dogma of the Immaculate Conception* (U Notre Dame Press, 1958) 125-126; T Engelhardt Jr., 'The Ontology of Abortion' (1974) 84 Ethics 217-234; J Mahoney, *Bioethics and Belief* (Sheed & Ward, 1984); R Gillon, 'Is there a 'new ethics of abortion'?' (2001) 27 J Med Ethics ii5-ii9.

<sup>10</sup> *Doogan*, paras. 11 and 33.

Act was intended to remedy (i.e., unsafe ‘backstreet’ abortions).<sup>11</sup>

Given the range of threats to women’s access to safe and timely reproductive healthcare, and to abortions specifically, both in the UK and elsewhere (despite the political battles that have won a legal foundation for abortion treatment<sup>12</sup>), and given the attempts, both in this case and beyond, to widen the scope and use of CO in the abortion setting, the UKSC might have taken this opportunity to explore more robustly the foundations of, and justifications for, abortion and CO, and the proper balance that ought to be struck by the medical profession in the use of the latter at the expense of the former. Their Lordships had clearly been invited to do so, but Lady Hale characterised the invitation as a ‘distraction’.<sup>13</sup> It is with this critically important ‘distraction’ that this paper engages. First, it briefly reviews some of the most pertinent criticisms that have been levelled against *Doogan*, arguing that the UKSC should have adopted an approach which relied more directly on human rights and morality. Second, it justifies this argument by considering the role and authority of the UKSC. Third, it offers a more holistic social and legal analysis of abortion and CO; taking the baton that the UKSC might have run with, it examines the legal foundation of the right to an abortion, and its support from, and indeed grounding in, international human rights law; it then outlines the foundation and scope of CO, noting how it has become a tool in the ongoing battle to undermine access to abortion; it then grounds the limitation of CO in the professional duties of the healthcare provider (i.e., physician, nurse, midwife). Fourth, it offers an alternative approach to the scope of s 4(1). It concludes that courts – particularly in jurisdictions that are widely persuasive, like the UK – when they are confronted with the opportunity to pronounce on important and controversial social and medical practices like CO within the healthcare context, should take full advantage.

## II. The Shortcomings of *Doogan*

As noted, in *Doogan*, Lady Hale approached the question of the scope of s 4(1) as a matter of standard statutory construction, drawing to some extent on a speculative understanding of what was in the mind of the legislators when they enacted the provision almost 50 years ago.<sup>14</sup> In doing so, she focused her attention on the meaning of ‘treatment’ and ‘to participate in’, as supported by the wording of the Act, noting in the process the position of the parties.<sup>15</sup>

With respect to ‘treatment’, Lady Hale held that the 1967 Act took a process position (i.e., understood treatment as including the full course of activities that directly brought about the end of the pregnancy).<sup>16</sup> With respect to ‘participation’, she identified a broad and a narrow reading; the broad reading encompassed both direct and indirect or hands-off involvement (i.e., taking calls, allocating staff, providing food, etc.), and the narrow reading comprised only hands-on involvement

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<sup>11</sup> *Doogan*, para. 27.

<sup>12</sup> On the changing nature of abortion politics: D McBride Stetson (ed.), *Abortion Politics, Women’s Movements and the Democratic State* (OUP, 2001); D Halfmann, *Doctors and Demonstrators: How Political Institutions Shape Abortion Law in the United States, Britain and Canada* (U Chicago Press, 2011), who notes how politicians in the UK have consistently shied away from engaging with anything to do with abortion. Indeed, the discussions around the adoption of the *Human Fertilisation and Embryology (Research Purposes) Regulations 2001/188* were circumscribed by a desire to avoid debates about abortion: S Parry, ‘The Politics of Cloning: Mapping the Rhetorical Convergence of Embryos and Stem Cells in Parliamentary Debates’ (2003) 22 *New Genetics & Society* 177-200.

<sup>13</sup> *Doogan*, paras. 23-27.

<sup>14</sup> *Doogan*, para. 38. But she failed to take notice of the complex and conflictual process by which the 1967 Act was developed and adopted, and of the rivalries within the medical profession that informed its content: McGuinness and Thomson, note 1, who, after noting the precarious position of abortion services, characterise abortion as a contested boundary issue that helped to redefine the understanding of proper medical practice in a setting that was fraught with uncertainty.

<sup>15</sup> *Doogan*, paras. 33-36.

<sup>16</sup> *Doogan*, para. 33. *Approving of Royal College of Nursing of the UK v Department of Health and Social Security* [1981] AC 800 (HL).

in the medical procedure itself. She chose the latter in defining the scope of CO,<sup>17</sup> stating:

[T]he course of treatment to which the petitioners may object is the whole course of medical treatment bringing about the termination of the pregnancy. It begins with the administration of the drugs designed to induce labour and normally ends with the ending of the pregnancy by delivery of the foetus, placenta and membrane. It would also, in my view, include the medical and nursing care which is connected with the process of undergoing labour and giving birth – the monitoring of the progress of labour, the administration of pain relief, the giving of advice and support to the patient who is going through it all, the delivery of the foetus, which may require the assistance of forceps or an episiotomy, or in some cases an emergency Caesarian section, and the disposal of the foetus, placenta and membrane. In some cases, there may be specific aftercare which is required as a result of the process of giving birth, such as the repair of an episiotomy.<sup>18</sup>

She held that the right to CO does not extend to things done before the course of treatment begins, such as making the booking before the first drug is administered, or to other managerial or administrative things done in connection with the treatment, such as assigning, supervising, or supporting staff, or monitoring patients in the ward afterwards.<sup>19</sup> And she held that it does not permit physicians to avoid referring patients to a colleague who does not hold any objections.<sup>20</sup>

*Doogan* has already been subject to an incisive and compelling critique which demonstrates the uncertainty associated with the UKSC's analytical foundation, and so the weaknesses in its analysis and conclusions.<sup>21</sup> In that critique, Neal observes that the mischief which the 1967 Act was meant to alleviate was actually a lack of legal clarity around the position of abortions and when they might be lawfully conducted, an ambiguity highlighted by the very different positions that the parties to the litigation adopted with respect to the term treatment. She argues that the UKSC, in determining the scope of s 4(1), therefore appears to rely on an understanding of what was previously criminal, a faulty approach that led to a number of unfounded conclusions.<sup>22</sup> In the course of her critique, Neal observes that the 1967 Act both decriminalised *and medicalised* abortion, shifting it to an NHS setting. In doing so, it established abortion as a treatment *process* in which a team of healthcareers in a structured and accountable clinical context are active in service delivery. As such, a wider understanding of both 'treatment' and 'participation' was warranted.<sup>23</sup> She continues as follows:

[A]pproaching the scope of a conscience-based exemption by acknowledging the nature and purpose of such provisions must be preferable to approaching it in a way that ignores them; and when the issue is viewed through the lens of moral responsibility, it is immediately apparent that someone who authorises a process (for example, the general practitioner who signs the form) has moral responsibility for it, as do those who support the process by arranging practicalities, allocating

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<sup>17</sup> *Doogan*, paras. 34-38. Reaffirming *Janaway v Salford Area General Authority* [1989] AC 537 (HL).

<sup>18</sup> *Doogan*, para. 34.

<sup>19</sup> *Doogan*, paras. 37-38.

<sup>20</sup> *Doogan*, para. 40.

<sup>21</sup> M Neal, 'When Conscience Isn't Clear: *Greater Glasgow Health Board v Doogan and Another* [2014] UKSC 68' (2015) 23 Med Law Rev 1-15.

<sup>22</sup> *Ibid*, at 9.

<sup>23</sup> *Ibid*, at 10 and 11. For more on the process and machinery associated with abortion services in the UK, see J Montgomery, 'Conscientious Objection: Personal and Professional Ethics in the Public Square' (2015) 23 Med Law Rev 200-220, at 202-203.

tasks, and supervising those directly involved.<sup>24</sup>

In short, the uncertainty that suffused the practice setting at the time of adoption (which undermines the utility of references to prior practice and legislative intent), combined with the unclear and apparently alternating foundation of the UKSC's analysis, led the UKSC to interpret the scope of CO in an impoverished manner. It should have understood that the treatment process begins before the labour-inducing administration of drugs, and that it includes the support given in recovery. Thus, many more individuals 'participate' in abortion 'treatment' than allowed for by the UKSC.

### III. The Road Not Taken in *Doogan*

The UKSC was invited to consider the dispute from a rights perspective, and to interpret the contested provision with reference to Article 9 (freedom of religion) of the European Convention on Human Rights (1950) (ECHR).<sup>25</sup> Lady Hale stated that there had been discussion in the proceedings about the relevance of such rights,<sup>26</sup> but she declined to consider the rights and obligations of the parties with reference to the ECHR, or to apply a rights-informed analysis of the provision. Characterising a rights approach as a 'distraction', she stated that a consideration of Article 9 would not be helpful because it is a qualified right subject to limitations that would implicate employer restrictions that would themselves be context-specific, and so any answers arrived at would point neither to a wide nor a narrow reading of the right to CO within the 1967 Act.<sup>27</sup> She also suggested that the UKSC was not equipped to 'speculate' on the broader consequences of enunciating a wide or narrow meaning of s 4(1), saying that it did not have the evidence by which to resolve the competing claims being made in relation thereto.<sup>28</sup>

In essence, Lady Hale side-lined the obvious and important moral and human rights aspects of the case and thereby denied the parties, the implicated health services, the public, and indeed the participants in international and domestic abortion politics, a usefully contextual and rights-informed interpretation of an important and precarious piece of health legislation and a right enunciated therein. Neal observes that the UKSC should have taken much more seriously its task of articulating and justifying the scope of s 4(1), bearing in mind the moral character of the right and the broader responsibilities of healthcarers.<sup>29</sup> I concur. But Lady Hale declined to take up the role that we might reasonably expect of her as a member of a country's highest and unifying court.

On the matter of role, one might note that *Doogan* was an appeal from Scotland, for which the UKSC is the final civil court of appeal.<sup>30</sup> Civil appeals may involve constitutional, public administration, or human rights issues (i.e., the UKSC has jurisdiction to hear cases relating to the common law or statutory law, including issues implicating the *Human Rights Act 1998* (1998 Act),<sup>31</sup> and the *Scotland Act 1998* (SCA 1998)<sup>32</sup>).<sup>33</sup> The UKSC is also the final court of appeal for

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<sup>24</sup> Neal, *ibid*, at 12, where she uses an example of the processing of Jews at Auschwitz during the Nazi regime in Germany.

<sup>25</sup> ETS 005, Rome, in force 3 September 1953.

<sup>26</sup> *Doogan*, para. 23.

<sup>27</sup> *Doogan*, para. 23.

<sup>28</sup> *Doogan*, paras. 25-27.

<sup>29</sup> She suggests that the UKSC could have but failed to 'add value' to the lower court's decision: Neal, note 21, at 15.

<sup>30</sup> See s 40, *Court of Session Act 1988*, as amended by the *Constitutional Reform Act 2005*, and UKSC, *Supreme Court Practice Direction 4: Notice of Appeal* (2015), at para. 4.2.2.

<sup>31</sup> 1998, c. 42.

<sup>32</sup> 1998, c. 46.

<sup>33</sup> UKSC, *The Jurisdiction of the Supreme Court of the United Kingdom in Scottish Appeals: Human Rights, the Scotland Act 2012 and the Courts Reform (Scotland) Act 2014* (2015), at 1.

purposes of considering the ECHR, and so for appealing cases to the European Court of Human Rights (ECtHR). Though the UKSC cannot *raise* issues under the ECHR,<sup>34</sup> s 3(1) of the 1998 Act *obligates* the UKSC to interpret legislation in a manner compatible with the 1998 Act (and the ECHR).<sup>35</sup> So rights should be directly engaged with when they are implicated, as they were in *Doogan*. A further argument for a more robust and rights-sensitive approach can be found in the stated expectation that the impact of the UKSC's decisions will extend far beyond the parties involved in any given case; they are expected to shape society more broadly,<sup>36</sup> and so of course would need to acknowledge the social context in which the decision operates.

On the latter point, Aharon Barak, President of the Supreme Court of Israel, states that the primary concern of a supreme court in a democracy is not to correct individual mistakes in lower court judgments, but rather to concern itself with broader, system-wide corrective action, which corrective action should focus on two main issues: bridging the gap between law and society; and protecting democracy.<sup>37</sup> On the matter of bridging the gap, Barak has elaborated as follows:

The law regulates relationships between people. It prescribes patterns of behavior. It reflects the values of society. The role of the judge is to understand the purpose of law in society and to help the law achieve its purpose. But the law of a society is a living organism. It is based on a given factual and social reality that is constantly changing. Sometimes the change is drastic, sudden, and easily identifiable. Sometimes [it] is minor and gradual, and cannot be noticed without the proper distance and perspective. Law's connection to this fluid reality implies that it too is always changing. Sometimes change in law precedes societal change and is even intended to stimulate it. In most cases, however, a change in law is the result of a change in social reality. Indeed, when social reality changes, the law must change too. Just as change in social reality is the law of life, responsiveness to change in social reality is the life of the law. It can be said that the history of law is the history of adapting the law to society's changing needs. A thousand years of common law are a thousand years of changes in the law in order to adapt it to the needs of a changing reality. The judge is the primary actor in effecting this change.<sup>38</sup>

In short, it is incumbent on courts like the UKSC to place their decisions in the broader social context, and to be aware of that context and its needs when formulating their judgments. In doing so, courts must be particularly aware of human rights and the limits placed on them, always striving to determine and protect the integrity of the balance between them.<sup>39</sup>

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<sup>34</sup> Ibid, at 3.

<sup>35</sup> UKSC, *The Supreme Court and Europe*, at <https://www.supremecourt.uk/about/the-supreme-court-and-europe.html> [accessed 15 August 2016].

<sup>36</sup> UKSC, *Significance to the UK*, at <https://www.supremecourt.uk/about/significance-to-the-uk.html> [accessed 15 August 2016]. It has been argued that the judicial reforms which led to the creation of the UKSC was a conscious push toward greater judicial independence and incursion into legislative and policy matters: M Fennell, 'Emergent Identity: A Comparative Analysis of the New Supreme Court of the United Kingdom and the Supreme Court of the United States' (2008) 22 Temple Int & Comp LJ 279-306.

<sup>37</sup> A Barak, 'A Judge on Judging: The Role of a Supreme Court in a Democracy' (2002-2003) 119 Harvard Law Rev 19-162, at 27-28, citing B Laskin, 'The Role and Functions of Final Appellate Courts: The Supreme Court of Canada' (1975) 53 Can Bar Rev 469, and W Rehnquist, 'The Changing Role of the Supreme Court' (1986) 14 FSU Law Rev 1-14.

<sup>38</sup> Ibid, at 28-29, citing B Cardozo, *The Paradoxes of Legal Science* (Greenwood Press, 1970), J Stone, *Legal System and Lawyers' Reasoning* (Stanford U Press, 1968), and B Dickson, 'A Life in the Law: The Process of Judging' (2000) 63 Sask Law Rev 373-388.

<sup>39</sup> Ibid, at 44. The adoption of the *Constitutional Reform Act 2005*, which created the UKSC, led to much debate about the future position of Parliamentary Sovereignty and judicial review in the (new) British constitutional order, with some seeing it as a step toward greater judicial independence, EU integration, and

The above suggests that the UKSC had the authority – indeed the responsibility – to bring the relevant human rights to bear when interpreting this contested statutory provision. Moreover, when adjudging the provision, it need not have felt constrained from placing both the case and the provision in their broader social contexts; it is empowered and expected to contextualise the case before it and to offer an interpretation that serves society as well as the parties. In *Doogan*, the UKSC was asked to interpret a statutory right that has obvious human rights foundations, and that affects a persistently contested but lawful medical procedure that also has clear human rights implications. The UKSC therefore might have begun its substantive judgment by placing the treatment at issue (abortion), the contested practice (CO), and the roles of healthcare workers in their broader moral, social and rights context, and from there reasoned its way to an appropriate scope for s 4(1) that made sense in the 21st century. Had it done so, the UKSC would have rendered a judgment that was richer, more satisfying, and more useful in light of the potentially wide availability and increasing use of CO.<sup>40</sup> Its narrow interpretive approach must be viewed as an inappropriately spurned opportunity to reaffirm abortion and to articulate the right to CO relative thereto, making clear that its understanding of CO may well have relevance in other healthcare contexts.

#### **IV. An Alternative and Better (?) Approach**

Lady Hale stated at the outset that the case was about the precise scope of the right of CO.<sup>41</sup> Obviously, an interpretation of the provision which grants the right is necessitated. However, rather than acknowledge the need to interpret the provision in a way compatible with ECHR rights but then decline to do so because the exercise of the CO would be undertaken in employment settings that would each have unique circumstances,<sup>42</sup> Lady Hale might have highlighted that what was at issue in this case was both access to, and participation in, a contested but lawful (and indeed critical) medical treatment; that an interpretation of s 4(1) necessarily implicated, and so must be informed by, a woman's right to reasonable reproductive health, choice and healthcare, and by a healthcare worker's potentially countervailing right to exercise personal moral choice in a professional context that has special moral and ethical features and imposes special and sometimes onerous and unwelcome obligations. The following is an analysis akin to that which might have been undertaken by the UKSC; it is a moral and human rights-based justification of access to abortion, and a rights-based consideration of CO and its position in the caring context having reference to an ethics-conscious elucidation of the healthcare worker's responsibilities.

##### **A. The Right to Reproductive Health and Access to Abortion**

It is axiomatic that all individuals have moral and legal claims to reasonable healthcare as a function of their being human. Indeed, it has been observed that the wellbeing, productivity, and vibrancy of individuals, communities, and societies is linked directly to individual and community health, a fact

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more robust review. Regardless of where individuals stand on this debate, it is generally agreed that the power of the Court to review legislative provisions and actions that are within the scope of the 1998 Act is clearly established: M Skold, 'Reform Act's Supreme Court: A Missed Opportunity for Judicial Review in the United Kingdom?' (2007) 39 Conn Law Rev 2149-2182.

<sup>40</sup> I am not here suggesting that the UKSC should have undertaken a review of the 'constitutionality' of the provision in relation to its compatibility with the implicated human rights. Rather, I am suggesting that the UKSC should have formulated its understanding of the subject provision (and right) having regard to the human rights implicated. As such, I take no position on the ongoing debate about the constitutional role of the UKSC with respect to Parliamentary Sovereignty and the striking down of legislative provisions.

<sup>41</sup> *Doogan*, para. 1.

<sup>42</sup> Which is what Lady Hale did in *Doogan*, para. 23.



which gives healthcare a special (moral) character.<sup>43</sup> And such is recognised and fully endorsed by the international human rights framework to which the UK has subscribed through its adoption of the *Human Rights Act 1998* and its ratification of human rights conventions.

For example, the Preamble of the WHO Constitution (1946)<sup>44</sup> recognises that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being. Article 25 of the Universal Declaration of Human Rights (1948) (UDHR)<sup>45</sup> states that everyone has the right to a standard of living adequate for their health and wellbeing, including medical care. Article 12(1) of the International Covenant on Economic, Social and Cultural Rights (1966) (ICESCR),<sup>46</sup> states that everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. Other instruments that acknowledge the right to healthcare include the African Charter on Human and People's Rights (1982),<sup>47</sup> the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (1988),<sup>48</sup> the Convention on the Rights of the Child (1989),<sup>49</sup> the European Social Charter 1996 (Revised),<sup>50</sup> and the European Convention on Human Rights and Biomedicine (1997).<sup>51</sup> It has also been reported that the right is enshrined in over 100 constitutional provisions around the world.<sup>52</sup> And the right has given rise to, and been vindicated in, important jurisprudence.<sup>53</sup> Ultimately, the right to reasonable healthcare without discrimination has been widely (and rightly) accepted as a juridical right (as opposed to a socio-political aspiration), although the practical contours and limitations of the right are subject to multiple social and economic factors.

A second socio-moral truth is that women deserve special attention and protection as a result of their special physiological role as child-bearers. In this regard, it must be recognised that reproduction is 'transformative' for women; it impacts on physical wellbeing, individual and family priorities and aspirations, identity, and financial security.<sup>54</sup> For example, pregnancy causes massive physical changes (e.g., uterus expansion, organ displacement, hormonal surges, weight gain, nausea, pain), has common complications (e.g., profound nausea, pre-eclampsia, gestational diabetes, obstetric fistula), and permanent side-effects (e.g., pelvic floor disorders, periodic urinary incontinence, etc.). Educational possibilities can be delayed or lost, especially for single mothers,

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<sup>43</sup> L Gostin, 'Securing Health or Just Health Care? The Effect of the Health Care System on the Health of America' (1994) 39 St Louis ULJ 7-44; M Low, B Low et al., 'Can Education Policy Be Health Policy? Implications of Research on the Social Determinants of Health' (2005) 30 J Health Pol, Policy & Law 1131-1162.

<sup>44</sup> Adopted by the International Health Conference, New York, 19 June to 22 July 1946, signed on 22 July 1946, in force on 7 April 1948. Present version in WHO, *Basic Documents*, 45th ed., Supplement (WHO, 2006).

<sup>45</sup> UNGA Res 217 A (III), 10 December 1948.

<sup>46</sup> UNGA Res 2200A (XXI), 16 December 1966, in force on 3 January 1976.

<sup>47</sup> OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58, 27 June 1981, in force 21 October 1986, Article 16.

<sup>48</sup> TS No. 69, San Salvador, 17 November 1988, in force 16 November 1999, Article 10.

<sup>49</sup> UNGA Res 44/25, 20 November 1989, in force 2 September 1990, Article 24.

<sup>50</sup> ETS No. 163, Strasbourg, in force 1 July 1999, Article 11.

<sup>51</sup> ETS No. 164, Oviedo, 4.IV.1997, in force 1 December 1999, Article 3. Though the UK has not ratified this convention.

<sup>52</sup> P Hunt, UN Special Rapporteur, 'The Human Right to the Highest Attainable Standard of Health: New Opportunities and Challenges' (2006) 100 Trans Royal Society Tropical Med & Hygiene 603-607.

<sup>53</sup> See *Vo v France* [2004] 2 FCR 577, wherein the ECtHR held that the status and dignity of the living individual properly outweighs that of the foetus, which means that it has no status in law to override or infringe upon the pregnant woman's liberty to make decisions for herself. See *Artavia Murillo v Costa Rica* (2012) Inter-American Court (Ser. C) No. 257, wherein the IACHR held that the American Convention on Human Rights (1969) protects individuals' rights to reproductive autonomy, and imposed on Member States an obligation to regulate and oversee the provision of health services to ensure effective protection of the rights to life and personal integrity of women. See also *Mondoza et al. v Ecuador (Ministry of Public Health) et al.*, Resolución No. 0749-2003-RA, 28 January 2004.

<sup>54</sup> L Finer, L Frohwirth, et al., 'Reasons US Women Have Abortions: Quantitative and Qualitative Perspectives' (2005) 37 Persp on Sexual Repro Health 110-118.

and securing employment can be more complicated before and during pregnancy, and difficult to retain after pregnancy. Finally, there are manifold social and emotional consequences. All of this points to the fact that a woman's dignity and individual flourishing is directly and profoundly influenced (and potentially undermined) by reproduction, with the consequence that her choices associated with reproduction must be facilitated as a matter of moral correctness.

Unfortunately, women's health has long and persistently (and to devastating effect) been marginalised,<sup>55</sup> and the right to terminate an unwanted pregnancy has long and widely been considered a crime (and is still so considered in some countries).<sup>56</sup> Through persistent social, political and legal action, and facilitated by feminism, the social movements of the 1960s, and the growing power of the human rights paradigm, laws against abortion have slowly and unevenly been liberalised.<sup>57</sup> This process, together with the physiological and social consequences of pregnancy noted above, has made clear that access to abortion treatment is rightly characterised as a moral entitlement.<sup>58</sup> And the long-standing and universally held socio-moral values of human dignity, equality (or equity), and autonomy, are obviously engaged (to the benefit of the woman) in the reproduction context.

Given the above, Article 25 UDHR stipulates that motherhood and childhood are entitled to special care and assistance. Article 10(2) ICESCR states that special protection should be accorded to mothers during a reasonable period before and after childbirth. Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (1979) (Women's Convention),<sup>59</sup> which condemns all discrimination against women and which characterises the refusal of medical procedures that only women require as sexual discrimination, states:

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.
2. ... States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary ...

In a similar vein, the 1994 Programme of Action of the International Conference on Population and Development (ICPD) explicitly recognised that reproductive rights are human rights:

Reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents and other relevant UN consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also

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<sup>55</sup> UN Economic and social Council, *Report of the Special Rapporteur: The Right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (2004), E/CN.4/2004/49.

<sup>56</sup> The devastating impact that the criminalisation of abortion and the practices of CO have had on women has been observed: UN Special Rapporteur, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Interim Report*, A/66/254 (2011).

<sup>57</sup> Halfmann, note 12; R Boland and L Katzive, 'Developments in Laws on Induced Abortion: 1998-2007' (2008) 34 *Int Family Plann Perspect* 110-120.

<sup>58</sup> Though it has been claimed that there are difficulties in mounting a moral defence of abortion: C McLeod, 'Referral in the Wake of Conscientious Objection' (2008) 23 *Hypatia* 30-47.

<sup>59</sup> UNGA Res 34/180, UN GAOR 34th Sess., Supp No 44, at 193, in force on 3 September 1981.

includes the right to make decisions regarding reproduction free of discrimination, coercion and violence ...<sup>60</sup>

The conviction that reproductive health is an integral component of health, and that it is a human right, was accepted at the Fourth World Conference on Women (1995),<sup>61</sup> and at subsequent conferences in 1999,<sup>62</sup> and 2000.<sup>63</sup> The international Inter-Agency Safe Motherhood Initiative, advanced in partnership with the WHO, UNICEF, and others, has also underlined the social burden and injustice of preventable maternal mortality.<sup>64</sup> In recognition of this, the Parliamentary Assembly of the Council of Europe (PACE) adopted Resolution 1607 (2008),<sup>65</sup> which invites Member States to:

- decriminalise abortion within reasonable gestational limits, guarantee women's effective exercise of their right of access to a safe and legal abortion;
- allow women freedom of choice and offer the conditions for a free and enlightened choice;
- lift restrictions which hinder access to safe abortion, which includes taking practical and financial steps to create conditions for health, medical and psychological care in relation to abortion.

All told, a right to reproductive health (and healthcare) has a strong and explicit foundation in key human rights instruments, and where reproductive health – which obviously encompasses safe and effective termination of an unwanted pregnancy – is not explicitly identified, it nonetheless 'lives' within the widely enumerated rights to personal security and liberty. In that regard, the Canadian abortion case, *R v Morgentaler*,<sup>66</sup> is an important benchmark. In *Morgentaler*, s 251 CCC<sup>67</sup> was

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<sup>60</sup> UN, *Programme of Action* (1994), International Conference on Population and Development, Cairo, 5-13 September 1994, UN Doc. A/CONF171/13/Rev 1 (1995), at 7.3; now published as UN, *Programme of Action* (2014).

<sup>61</sup> UN, *Beijing Declaration and Platform for Action* (1995), Fourth World Conference on Women: Action for Equality, Development and Peace, Beijing, UN Doc A/CONF. 177/20.

<sup>62</sup> UN, *Report of the Ad Hoc Committee of the Whole of the 21st Special Session of the General Assembly: Overall Review and Appraisal of the Implementation of the Programme for Action of the ICPD* (1999), UN Doc A/S-21/5/Add.1.

<sup>63</sup> UN, *Report of the Ad Hoc Committee of the Whole of the 23rd Special Session of the General Assembly: Further Actions and Initiatives to Implement the Beijing Declaration and the Platform for Action* (2000), UN Doc A/S-23/10/Rev.1.

<sup>64</sup> More on which can be found at [www.who.int/en/](http://www.who.int/en/).

<sup>65</sup> PACE, *Resolution 1607 (2008): Access to Safe and Legal Abortion in Europe*, 15th Sitting of the Assembly, 16 April 2008.

<sup>66</sup> [1988] 1 SCR 30. Obviously, one of the early and most important judicial considerations of the right to an abortion (as a constituent component of reproductive health) is *Roe v Wade* (1973) 410 US 113 (USSC), which has been reaffirmed, albeit narrowly, in *City of Akron v Akron Center for Reproductive Health Inc.* (1983) 462 US 416 (USSC), *Thornburgh v American College of Obstetricians and Gynecologists* (1986) 106 S Ct 2169, *Webster v Reproductive Health Services* (1989) 109 S Ct 3040, and *Planned Parenthood of Southeastern Pennsylvania v Casey* (1992) 112 S Ct 2791, although more and more restrictions on access have been permitted. However, *Roe v Wade* reflects the USA's unique constitutional and political character. For background on the political significance of *Roe v Wade*, see L Greenhouse and R Siegel, 'Before (and After) *Roe v. Wade*: New Questions About Backlash' (2011) 120 Yale LJ 2028-2087. For more on abortion in the USA, see B Alvarez Manninen, 'Rethinking *Roe v. Wade*: Defending the Abortion Right in the Face of Contemporary Opposition' (2010) 10 Am J Bioethics 33-46.

<sup>67</sup> Subsections 251(1) and (2) created an offence for any person to use any means to procure a miscarriage for a woman, and for any woman to use any means to procure her own miscarriage. Subsection 251(3) defined 'means' as the administration of a drug or other noxious thing, the use of an instrument, and

challenged as infringing security of the person under s 7 of the Canadian Charter of Rights and Freedoms (Charter),<sup>68</sup> which section reflects Article 5 ECHR. On the facts, which included evidence relating to the terrible difficulty encountered by women trying to meet the s 251(4) conditions, a majority of the Supreme Court held that women were exposed to a threat to their physical and psychological security, and that s 251 could not be saved under the limiting provision of s 1 of the Charter.<sup>69</sup> In the result, reliance on therapeutic panels (which is a feature of the conditions for securing a lawful abortion under s 1(1) of the 1967 Act) was struck down as unconstitutional.<sup>70</sup>

*Morgentaler* is noteworthy not only for the grounding of access to abortion on international human rights-informed Charter rights, but also for some of the broader observations offered. For example, Dickson CJC, in finding a Charter breach, stated:

Forcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman's body and thus a violation of security of the person.<sup>71</sup>

In her concurring judgment, the redoubtable Wilson J observed that, in addition to security, s 7 speaks to liberty. As such, individuals have guaranteed to them a degree of autonomy in making decisions of fundamental personal importance; they have the right to develop and realise their potential to the fullest, to plan their own life to suit their own character, and to make their own choices so long as one does not attempt to deprive others of their liberty in the process. On the special significance of abortion to women, Wilson J stated:

It is probably impossible for a man to respond, even imaginatively, to such a dilemma not just because it is outside the realm of his personal experience (although this is, of course, the case) but because he can relate to it only by objectifying it, thereby eliminating the subjective elements of the female psyche which are at the heart of the dilemma. ... [T]he history of the struggle for human rights from the eighteenth century on has been the history of men struggling to assert their dignity and common humanity against an overbearing state apparatus. The more recent struggle for women's rights has been a struggle to eliminate discrimination, to achieve a place for women in a man's world, to develop a set of

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manipulation of any kind. Subsection 251(4) enunciated the conditions under which an abortion was lawful, namely when a 3-member therapeutic abortion committee of an accredited hospital considered the case and issued a certificate stating that the continuation of the pregnancy would likely endanger the pregnant woman's life or health, and the certificate was received by a separate medical practitioner who was then permitted to perform an abortion.

<sup>68</sup> Section 7 states: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."

<sup>69</sup> Section 1 states: "The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."

<sup>70</sup> But wide discrepancies in the availability of, and the conditions for, abortion services remain. On providers: Quebec is the best, with 31 of 129 hospitals plus 36 clinics offering abortions; in British Columbia, 26 of 90 hospitals plus 6 clinics; in Ontario, 33 of 194 hospitals plus 11 clinics; in Nova Scotia, only 4 of 30 hospitals and 0 clinics; in Prince Edward Island, no service is provided. On conditions: Quebec, Ontario and BC all allow for self-referral (i.e., access without referral from a GP or physician), and make treatment available up to 23, 24 and 20 weeks of gestation respectively. Nova Scotia does not allow self-referral, and it imposes a gestational limit of 15 weeks (with no medicinal abortions). New Brunswick, the Yukon and Nunavut impose gestational limits of 12 weeks. M Reid, 'Access by Province' at <http://www.morgentaler25years.ca/the-struggle-for-abortion-rights/access-by-province/> [accessed 29 April 2016].

<sup>71</sup> *Morgentaler*, at 32-33.

legislative reforms in order to place women in the same position as men ... It has not been a struggle to define the rights of women in relation to their special place in the societal structure and in relation to the biological distinction between the two sexes. Thus, women's needs and aspirations are only now being translated into protected rights. The right to reproduce or not to reproduce which is in issue in this case is one such right and is properly perceived as an integral part of modern woman's struggle to assert her dignity and worth as a human being.<sup>72</sup>

On the matter of access to abortion treatment, the Committee on Economic, Social and Cultural Rights, tasked with monitoring the ICESCR, has issued *General Comment 14*,<sup>73</sup> which explains, at para. 12, that the right to healthcare requires compliance with certain performance standards:

- availability (services must be available in sufficient quantity);
- accessibility (services, including information, must be physically and economically accessible to everyone without discrimination);
- acceptability (services must be culturally appropriate and sensitive to gender and life-cycle requirements); and
- adequacy (services must be scientifically appropriate and of sufficient quality).

Several important moral and legal propositions are supported. First, equitable access to adequate healthcare is a universally accepted human right, and that right includes a right to reproductive healthcare. Second, women's health, which has long been marginalised as a result of sexual, gender and reproductive discrimination, has special status and demands special protection. Third, abortion, as a critical element of reproductive healthcare, is morally justified as a condition of respecting women's dignity, autonomy, equality, and citizenship (women should not be forced to incubate and feed another against their will).<sup>74</sup> Fourth, conscious political and legal efforts have been undertaken to legalise abortion, and to include it in the public health system; this has sometimes been done explicitly and positively, and sometimes less positively.

For an example, note South Africa's *Choice on Termination of Pregnancy Act 1997*, which explicitly states in para. 4 of the Preamble that the decision to have children is fundamental to a woman's physical, psychological, and social health, and that universal access to reproductive healthcare includes access to family planning and contraception, *termination of pregnancy*, and sexual education and counselling. For a negative approach, we have the 1967 Act, which, without explicitly placing abortion in the broader treatment setting, makes abortion 'lawful' in certain circumstances; s 1(1) states that a person shall not be guilty of an offence when a pregnancy is terminated by a registered medical practitioner so long as two registered medical practitioners are of the opinion, formed in good faith, that:

- a. the pregnancy has not exceeded its 24th week and its continuance would involve greater risk of injury to the physical or mental health of the pregnant woman or any existing children of her family than its terminated; or
- b. the termination is necessary to prevent grave permanent injury to the physical or mental

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<sup>72</sup> Morgentaler, at 171-172.

<sup>73</sup> Committee on Economic, Social and Cultural Rights, *General Comment 14 on the Right to Health* (2000), UN CEDSCR 22nd Sess. UN Doc E/C.12/2000/4.

<sup>74</sup> A point made forcefully in R Cook and B Dickens, note 5.

health of the pregnant woman; or

- c. the continuance of the pregnancy would involve greater risk to the life of the pregnant woman than if it were terminated; or
- d. there is a substantial risk that the child, if born, would suffer from such physical or mental abnormalities as to be seriously handicapped.

In forming their opinion, the medical practitioners are permitted to take into account the pregnant woman's actual or reasonably foreseeable environment.<sup>75</sup> Ultimately, the 1967 Act legislatively enshrines access to an abortion, though it does so in a negative way. More precisely, it makes abortion treatment lawful under certain conditions, and in doing so it brings abortion within the highly structured system of the NHS, involving hospitals, health teams, and accountability.<sup>76</sup> In other words, the UK acted early to recognise the importance of abortion and to establish access, though its approach is not entirely inspired nor particularly inspiring.

#### **B. A Built-in Limitation: Conscientious Objection**

Of course, the rights on which abortion is grounded are not absolute, and conditions on access to abortion might be justified on a number of grounds, the most compelling of which is probably the controversial nature of the practice in light of divergent but (arguably) defensible moral positions. Another might be resource allocation, though it must be observed that abortions are typically quick and inexpensive day-surgeries; certainly less resource-intensive than birth-related services such as prenatal care, birthing attendance, neonatal intensive care, etc.<sup>77</sup> A further factor which impinges on the right to have an abortion, though it is *not* meant to actually serve as a limitation on access, is CO. As noted, s 4(1) states that no person is under a duty to participate in any treatment authorised by the 1967 Act to which he has a CO.<sup>78</sup>

The right to CO that is acknowledged in the 1967 Act is notionally founded on Article 18 UDHR, which is reproduced in Article 18(1) of the International Covenant on Civil and Political Rights (1966) (ICCPR),<sup>79</sup> which states:

Everyone shall have the right to freedom of thought, conscience and religion. This right shall include freedom to have or to adopt a religion or belief of his choice, and freedom, either individually or in community with others and in public or private, to manifest his religion or belief in worship, observance, practice and teaching.

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<sup>75</sup> Subsection 1(2), 1967 Act. In other words, the 'committee' can take into account the pregnant woman's family, broader social and economic situation, and any other relevant factors. Again, this requirement for multi-physician sanction was found to be unconstitutional in *Morgentaler*. And one can question why a woman's right of access to a treatment as fundamental to reproductive choice as abortion should be subject to such review, or even to referral (as opposed to available through direct self-appointment).

<sup>76</sup> 1967 Act, s 1(3), and so noted in *Doogan*, at para. 27, though Lady Hale subsequently and curiously denied that Parliament could have had in its contemplation the members of that team when legislating on CO.

<sup>77</sup> J Erdman, 'In the Back Alleys of Health Care: Abortion, Equality and Community in Canada' (2007) 56 Emory LJ 1093-1155.

<sup>78</sup> The only other explicit reference to CO in British medical law can be found in s 38 of the *Human Fertility and Embryology Act 1990*, as amended. However, CO is an entitlement that is also extended to practitioners through guidance issued by various professional bodies (see *infra*).

<sup>79</sup> UNGA Res 2200A (XXI), 16 December 1966, in force 23 March 1976.

This right to freedom of conscience and religion is reflected in Article 9(1) ECHR,<sup>80</sup> and is further reiterated in Article 9, Schedule 1, of the 1998 Act, and made operational through ss 1, 3 and 13.<sup>81</sup> This foundation for CO has been generally recognised.<sup>82</sup>

Of course, after erecting the right to freedom of conscience and religion, Article 18(3) ICCPR states that:

Freedom to manifest one's religion or beliefs may be subject only to such limitations as are prescribed by law and are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others.

Again, this limitation is reflected in Article 9(2) ECHR, and Article 9(2) Schedule 1, of the 1998 Act. Its consequence is that CO must also be viewed as a limited entitlement, particularly in the reproductive healthcare setting where, as demonstrated, other fundamental rights are in play, and where the consequences of non-vindication for treatment-seeking women are arguably much more profound than the consequences to the healthcarers participating against their conscience.

Of course, in *Doogan*, the UKSC did not address the broader rights-foundation of CO, and so did not offer any insight into its proper balancing as against the right to an abortion from a broader conceptual perspective. This was unfortunate because the failure to preserve legal prohibitions against abortion, or alternatively to impose restrictive conditions on access to abortions, has prompted anti-choice advocates to employ CO and other tactics to undermine the provision of timely and safe abortion services.

With respect to 'other tactics', it has been reported that, in the UK, access to abortion is threatened because the number of physicians trained in abortion treatment is falling.<sup>83</sup> This phenomenon is also discernible in other jurisdictions; in Canada, medical schools are neglecting to train physicians in this field,<sup>84</sup> while some physicians choose not to study in this specialty because they face harassment and violence out in practice.<sup>85</sup> While it might be improper to claim that this is a conscious programme of marginalisation on the part of medical schools, it is troubling to learn that less than an hour is spent teaching abortion in a 4-year curriculum, while magnitudes more time is spent discussing Viagra.<sup>86</sup> Other actions which undermine access to an abortion include a low and falling number of hospitals providing abortion services, management and administration decisions which require women to travel to find another provider, which can endanger their confidentiality,

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<sup>80</sup> Which states: "Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief and freedom, either alone or in community with others and in public or private, to manifest his religion or belief, in worship, teaching, practice and observance."

<sup>81</sup> Section 1(1) states that 'Convention rights' means the rights and freedoms set out in the ECHR, s 1(2) states that those rights have effect in the UK, s 3(1) states that, so far as is possible, legislation must be read and given effect in a way which is compatible with Convention rights, and s 13 states that, if a court's determination of any question arising under this Act might affect the exercise of the right to freedom of thought, conscience and religion, it must have particular regard to the importance of that right.

<sup>82</sup> UNHRC, *General Comment No. 22: The Right to Freedom of Thought, Conscience and Religion*, 48th Session, 1993, in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, vol. I, UN Doc. HRI/GEN/1/Rev. 9 (2008), at 204; EU Network of Independent Experts on Fundamental Rights, *Opinion No. 4-2005: The Right to Conscientious Objection and the Conclusion by EU Member States of Concordats with the Holy See*, 14 December 2005, CFR-CDF.Opinion 4-2005.doc.

<sup>83</sup> J Roe, C Francombe and M Bush, 'Recruitment and Training of British Obstetrician and Gynaecologists for Abortion Provision: Conscientious Objection Versus Opting Out' (1999) 14 *Repro Health Matters* 97-105; K Roslyn, 'Conscientious Objection to Termination of Pregnancy: The Competing Rights of Patients and Nurses' (2009) 17 *J Nursing Management* 907-912.

<sup>84</sup> A Koyama and R Williams, 'Abortion in Medical School Curricula' (2005) 8 *McGill J Medicine* 157-160.

<sup>85</sup> L Eggerton, 'Abortion Services in Canada: A Patchwork Quilt with Many Holes' (2001) 164 *CMAJ* 847-849.

<sup>86</sup> C Kaposy, 'Improving Abortion Access in Canada' (2010) 18 *Health Care Anal* 17-34.

their wellbeing, or their life.<sup>87</sup>

With respect to CO more specifically, McHale has noted a slow growth of ‘opt-out’ across healthcare provision,<sup>88</sup> a finding in keeping with Cantor’s warning about ‘conscience creep’ in the USA.<sup>89</sup> It has been reported that some 20% of British GPs are against abortion on the basis of their religious beliefs, and that some of them actively work to delay or prevent women from securing abortion services.<sup>90</sup> In at least one case, this has led to a claim of medical negligence against the physician.<sup>91</sup> It has also been reported that these GPs routinely impose their views about morality and conscientiousness on young women, who are one of the most vulnerable groups in this setting (at risk in no small part because they tend to be less aware of their rights).<sup>92</sup> And there have been efforts to expand the use of CO to more healthcarers and to more peripheral elements of abortion treatment, a case in point being *Doogan*, where the midwives objected to delegating, supervising and/or supporting staff to participate in, and provide care to, patients throughout the termination process.

Of course, the undermining of access to abortion and the misuse of CO is not just a UK problem. It is a global problem that is driven at least in part by conservative religious institutions intent on undermining women’s reproductive rights.<sup>93</sup> The uneven enjoyment of adequate reproductive healthcare across Europe has long been recognised,<sup>94</sup> and a range of bodies tasked with monitoring human rights and women’s health have repeatedly cited countries for their failure to comply with their obligations. For example, the Committee on the Elimination of Discrimination against Women (CEDAW), which monitors compliance with the Women’s Convention, has issued reports against Italy,<sup>95</sup> Croatia,<sup>96</sup> Poland,<sup>97</sup> and Slovakia.<sup>98</sup> Further examples include the following:

- Norway: CO was available to physicians, nurses and midwives, but it came to light that a growing number of GPs were refusing to refer patients to non-objectors. This led to a 2011 Regulation which banned CO.<sup>99</sup>

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<sup>87</sup> J Shaw, *Reality Check: A Close Look at Accessing Abortion Services in Canadian Hospitals* (Canadians for Choice, 2005).

<sup>88</sup> J McHale, ‘Conscientious Objection and the Nurse: A Right or a Privilege?’ (2009) 18 Br J Nursing 1262-1263.

<sup>89</sup> J Cantor, ‘Conscientious Objection Gone Awry: Restoring Selfless Professionalism in Medicine’ (2009) 360 N Engl J Med 1484-1485.

<sup>90</sup> E Lee, S Clements, et al., *A Matter of Choice* (J Rowntree Foundation, 2004).

<sup>91</sup> In *Enright v Kwun* [2003] EWHC 1000 (QB), the Court found a physician negligent for failing to counsel a patient on genetic screening, a failure that was, on the evidence, partially caused by his religious beliefs.

<sup>92</sup> J Coleman, ‘Meeting the Health Needs of Young People’ (2001) 55 J Epidemiology & Comm Health 532-533.

<sup>93</sup> L Finer and J Fine, ‘Abortion Law around the World: Progress and Pushback’ (2012) 103 Am J Public Health 585-589. For a report on the Philippines: C Ruiz Austria, ‘The Church, the State and Women’s Bodies in the Context of Religious Fundamentalism in the Philippines’ (2004) 12 Reproductive Health Matters 96-103. For a report on the plight of women in Latin America: R Cook, M Olaya, B Dickens, ‘Healthcare Responsibilities and Conscientious Objection’ (2009) 104 Int J Gynecology & Obstetrics 249-252. For the situation in parts of Africa: L-J Van Bogaert, ‘The Limits of Conscientious Objection to Abortion in the Developing World’ (2002) 2 Developing World Bioethics 131-143; V Lema, ‘Conscientious Objection and Reproductive Health Service Delivery in Sub-Saharan Africa’ (2012) 16 Afr J Reproductive Health 15-21.

<sup>94</sup> European Parliament, *Resolution on Sexual and Reproductive Health and Rights*, PA 2001/2128(INI) (2002).

<sup>95</sup> CEDAW, *Concluding Observations: Italy*, UN Doc. A/52/38 Rev. 1 (1997).

<sup>96</sup> CEDAW, *Concluding Observations: Croatia*, UN Doc. A/53/38 (1998).

<sup>97</sup> CEDAW, *Concluding Observations: Poland*, UN Doc. CEDAW/C/POL/CO/6 (2007).

<sup>98</sup> CEDAW, *Concluding Observations: Slovakia*, UN Doc. A/63/38 (2008).

<sup>99</sup> E Kibsgaard Nordberg, H Skirbekk, M Magelssen, ‘Conscientious objection to referrals for abortion: pragmatic solution of threat to women’s rights?’ (2014) 15 BMC Medical Ethics 1-9.



- France: In *Pichon & Sajous v France*,<sup>100</sup> two pharmacists were convicted when they refused to serve female customers. They claimed that their freedom to manifest their religion under the ECHR had been violated as a result of their conviction, but the ECtHR concluded that their refusal to sell contraceptives did not fall within the scope of the right to manifest a religious belief. It also emphasised that the pharmacists could not give priority to their personal beliefs over their professional obligations where the sale of such medicine was legal and could only occur by prescription at a pharmacy.<sup>101</sup>
- Poland: In *RR v Poland*,<sup>102</sup> a woman was denied a prenatal genetic examination in part as a result of the physician's conscientious objection. The ECtHR observed that her access to care was marred by procrastination and confusion, and that she was treated shabbily, resulting in acute anguish. It concluded that States are obliged to organise healthcare systems so that freedom of conscience does not prevent patients from securing services. In *P and S v Poland*,<sup>103</sup> the ECtHR reiterated that physician rights to object must be balanced with patient rights to access abortion. In fact, both the UN Human Rights Committee, which monitors compliance with the ICCPR, and the UN Committee on Economic, Social and Cultural Rights, which monitors compliance with the ICESCR, have expressed concern about Poland's measures to achieve quality, affordable reproductive health services.<sup>104</sup>
- Canada: It has been reported that anti-choice GPs have refused to provide referrals for abortions, and indeed have been known to give women misinformation about eligibility and timing, sometimes stalling in the provision of information until after the statutory gestational limits are passed.<sup>105</sup>
- USA: The misuse of CO is particularly acute.<sup>106</sup> State Legislatures have drafted statutory provisions permitting hospital administrators, ambulance attendants, and others to object on the basis of religion. For example, the Mississippi *Health Care Rights of Conscience Act 2004* opens the possibility of objecting to providers of any phase of patient care, including but not limited to referral, counselling, therapy, testing, diagnosis, research, instruction, prescribing, dispensing or administering devices, drugs or medication, surgery, or any other care.<sup>107</sup> Anti-choice advocates have since drafted a similar model statute and associated policy guidance for use in political lobbying and legal actions against abortion.<sup>108</sup> Also note the US foreign aid policy which restricts overseas NGOs that receive US aid from using any money (including their own private funds) to provide abortion services, to advocate for a

<sup>100</sup> [2001] ECHR 898 (ECtHR).

<sup>101</sup> B Knestout, 'An Essential Prescription: Why Pharmacist-Inclusive Conscience Clauses are Necessary' (2006) 22 J Contemp Health Law & Policy 349-382; L Davidson, C Pettis, et al., 'Religion and Conscientious Objection: A Survey of Pharmacists' Willingness to Dispense Medications' (2010) 71 Soci Sci Med 161-165.

<sup>102</sup> (2011) 53 EHRR 31 (ECtHR).

<sup>103</sup> [2012] ECHR 1853.

<sup>104</sup> UNHRC, *Concluding Observations: Poland*, UN Doc. CCPR/CO/82/POL (2004); CESCR, *Concluding Observations: Poland*, UN Doc. EC12/POL/CO/5 (2009); UNHRC, *Concluding Observations: Poland*, UN Doc. CCPR/C/POL/CO/6 (2010).

<sup>105</sup> Canadian Abortion Rights Action League, *Protecting Abortion Rights in Canada* (CARAL, 2003); J Hawkins and E Emauel, 'Clarifying Confusions about Coercion' (2005) 35 Hasting Centre Rep 16-19.

<sup>106</sup> Cantor, note 89.

<sup>107</sup> B Dickens, 'Ethical Misconduct by Abuse of Conscientious Objection Laws' (2006) 25 Medicine & Law 513-522.

<sup>108</sup> Americans United for Life, *Healthcare Freedom of Conscience Act: Model Legislation and Policy Guide* (2013).

liberalisation of their own abortion laws, or to offer full and accurate abortion information to patients.<sup>109</sup>

All told, the politico-legal environment routinely inhibits women from exercising their autonomy and determining their own course of medical treatment, and the exercise of CO has compounded this problem.<sup>110</sup> This interference with their ability to set their own conditions of existence, it has been argued, represents an unjust state of ‘domination’ which should not be tolerated.<sup>111</sup>

Because CO has been inordinately directed at interventions in women’s health, CEDAW issued *General Recommendation No. 24*.<sup>112</sup> Paragraph 6 states that special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups. Paragraph 11 adds that:

... It is discriminatory for a State party to refuse to provide legally for the performance of certain reproductive health services for women. For instance, if health service providers refuse to perform such services based on conscientious objection, measures should be introduced to ensure that women are referred to alternative health providers.

This makes clear that governments bear responsibilities to introduce measures to *ensure* that women can access care that some healthcarers may object to providing.<sup>113</sup> It reaffirms that, although CO is a right, it must be tempered by other rights (and historical wrongs). It also suggests that healthcarers are moral as well as public agents, and so their professionalism is relevant to the operation of this setting. As such, it is critical to consider the obligations of healthcarers when it comes to treatment provision and CO; such will permit a deeper appreciation of the role and position of CO within the caring profession, and a better articulation of how it might be managed by health authorities tasked with actioning governmental responsibilities and policies.

### **C. The Professional Healthcarer and CO**

It is important to first recognise that physicians must be *both scientifically and ethically* grounded (and educated) in order to perform their functions, which are undeniably public functions.<sup>114</sup> In other words, conscience and conscientiousness runs through all of their professional duties and judgments, and those duties include forming both ethically and scientifically sound clinical judgments, and thereby serving as (moral and trustworthy) gatekeepers to the NHS’s healthcare services. Indeed, Montgomery argues that cases such as *Re J*,<sup>115</sup> *R (Burke) v GMC*,<sup>116</sup> *AVS (by his*

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<sup>109</sup> US Agency for International Development, *Standard Provisions for US Grantees and US Subgrantees* (1985) 13 AID Handbook 4C-45-50, a policy introduced under the Reagan administration in 1984 and now known as the Global Gag Rule.

<sup>110</sup> And it is difficult to ascertain if the invocation of CO is due to an honest and deeply-held moral or religious belief, or rather to an ideological position intended to thwart women’s access to lawful reproductive treatments. Note that the 1967 Act explicitly instructs healthcarers to act in good faith.

<sup>111</sup> M Young, *Justice and the Politics of Difference* (NJ: Princeton U Press, 1990).

<sup>112</sup> CEDAW, *General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, 20th Session, 1999, in UN Document A/54/38/Rev.1, chap. I.

<sup>113</sup> This point is emphasised in Guidelines 1, 2 and 6 of International Federation of Gynaecology and Obstetrics, *Ethical Issues in Obstetrics and Gynaecology: Ethical Guidelines on Conscientious Objection* (2012), which affirms that a physician’s primary conscientious duty is to provide benefit and avoid harm to the patient, that healthcarers should not impose their values onto others, and that they may have to undertake treatment to which they object.

<sup>114</sup> Montgomery, note 23.

<sup>115</sup> [1991] 3 All ER 930 (CA).

*litigation friend CS) v An NHS Foundation Trust*,<sup>117</sup> *Aintree NHS Trust v James*,<sup>118</sup> and others, demonstrate both the integration of conscientiousness in health professionalism and the belief that the exercise of professional judgment is informed by moral considerations (i.e., that healthcare is a 'morally suffused activity').<sup>119</sup> That being so, healthcareers must be viewed as moral agents who are particularly sensitised to morality, or rather to ethically balanced assessments.

The morality or conscientiousness to which healthcareers must conform is informed at least in part by general and long-standing notions of medical ethics. The concept of 'medical etiquette' first appeared in Greece around 500 BCE and eventually coalesced into the Hippocratic Oath, which clearly states that a physician is there for the benefit of his patients, and must, to the best of her ability, do good, and additionally do nothing that will cause harm (thereby foreshadowing the contemporary principles of beneficence and non-maleficence).<sup>120</sup> Under the modern version of the Hippocratic Oath, which has global reach, physicians declare the following:<sup>121</sup>

I will apply, for the benefit of the sick, all measures which are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

The World Medical Association (WMA) has issued a Code which states that physicians *shall* maintain the highest standards of professional conduct, respect a competent patient's right to accept or refuse treatment, not allow his judgment to be influenced by personal profit or unfair discrimination, provide competent medical service in full professional and moral independence, with compassion and respect for human dignity, deal honestly with patients, and respect the rights and preferences of patients.<sup>122</sup>

The following examples go some way to demonstrating the moral/ethical character of the healthcare professions and how conscientiousness is intended to inform their day-to-day professional activities. The General Medical Council (GMC), which sets standards for students and physicians, instructs its members to, inter alia:<sup>123</sup>

- make the care of their patient their first concern;
- protect and promote the health of patients and the public;
- treat patients as individuals and respect their dignity, working with them, and responding to their concerns and preferences;
- give patients the information they want or need in a way they can understand so they can realise their right to reach decisions about their treatment; and

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<sup>116</sup> [2005] EWCA Civ. 1003.

<sup>117</sup> [2011] EWCA Civ. 7.

<sup>118</sup> [2013] UKSC 67.

<sup>119</sup> Montgomery, note 23, at 205-206. See also E. Pellegrino, 'Toward a Reconstruction of Medical Morality' (2006) 6 *Am J Bioethics* 65-71; C. Foster and J. Miola, 'Who's in Charge? The Relationship Between Medical Law, Medical Ethics, and Medical Morality?' (2015) 23 *Med Law Rev* 505-530.

<sup>120</sup> G. Laurie, S. Harmon, G. Porter, *Mason & McCall Smith's Law & Medical Ethics*, 10th ed. (OUP, 2016), ch. 1.

<sup>121</sup> Hippocratic Oath, Modern Version, written by Dean of Medicine Louis Lasagna, Tufts University, in 1964 and used in many medical schools. Available at <http://guides.library.jhu.edu/c.php?g=202502&p=1335759> [accessed 30 April 2016].

<sup>122</sup> WMA, *International Code of Medical Ethics*, revised at 57th WMA General Assembly, Pilanesberg, South Africa, October 2006, available at <http://www.wma.net/en/30publications/10policies/c8/index.html> [accessed 30 April 2016].

<sup>123</sup> GMC, *Good Medical Practice* (2013).

- never discriminate unfairly against patients or colleagues, or abuse their trust.

The International Council of Midwifery (ICM) recognises that pregnancy is a profound experience which carries significant meaning for the woman, and it articulates its philosophy in the following propositions:<sup>124</sup>

- Midwifery care promotes, protects and supports women's human, reproductive and sexual health and rights, and is based on the ethical principles of justice, equity, and respect for human dignity.
- Midwifery care is emancipatory as it protects and enhances the health and social status of women, and builds women's self confidence in their ability to cope with childbirth.
- Midwifery care takes place in partnership with women, recognising the right to self-determination, and is respectful, personalised, continuous and non-authoritarian.

The Royal College of Nursing (RCN), which oversees nurses and works in cooperation with the Nursing and Midwifery Council, instructs nurses and staff to treat patients with dignity and humanity, showing compassion and sensitivity, to engage and communicate with patients and put them first, and to lead by example.<sup>125</sup> A similar collection of virtue-grounded professional duties are espoused by other important professional bodies around the world.<sup>126</sup> Compliance with these duties has contributed to healthcareers constructing, by-and-large, a series of competent, public-serving professions the most virtuous members of which have placed patients above themselves and modelled high degrees of self-sacrifice.<sup>127</sup>

Subsection 4(1) of the 1967 Act relieves physicians (and other healthcareers) from having to justify their decision according to the above professional standards and values; it allows them to impose their *personal* sensibilities unclothed by clinical judgment or jargon (i.e., to expose and impose their personal values and views in the clinical setting in which they have professional and statutory obligations to serve steadfastly and without discrimination). In short, it allows them to retreat in some way from the value of beneficence, which is meant to shape their interactions with

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<sup>124</sup> ICM, *Philosophy and Model of Midwifery Care* (2014), CD2005\_001 V2014 ENG. The ICM also maintains an International Code of Ethics for Midwives (2014), CD2008\_001 V2014 ENG, and has issued a *Position Statement: Midwives' Provision of Abortion-Related Services* (2014), PS2008\_011 V2014. The latter stipulates that abortion is an essential element of basic reproductive health services, and that women who seek abortion services are entitled to be provided with such services by midwives.

<sup>125</sup> RCN, *Principles of Nursing Practice*, Principles A, D, E and H, at <https://www.rcn.org.uk/professional-development/principles-of-nursing-practice> [accessed 1 May 2016].

<sup>126</sup> In Canada, the Canadian Medical Association (CMA), notes that physicians may experience tension between different ethical principles, between ethical and legal or regulatory demands, or between their own ethical convictions and the needs of others, and then directs physicians to: consider first the well-being of the patient; refuse to participate in or support practices that violate basic human rights; recognize and disclose conflicts of interest and resolve them in the best interest of patients; inform patients when personal values would influence the recommendation or practice of any medical procedure that the patient needs or wants: CMA, *CMA Code of Ethics* (2004), last reviewed March 2015. The Canadian Nurses Association (CNA) identifies the following values as underpinning good nursing practices: providing safe, compassionate, competent and ethical care; promoting health and well-being; promoting and respecting informed decision-making; preserving dignity; maintaining privacy and confidentiality; promoting justice; and being accountable: CNA, *Code of Ethics for Registered Nurses* (2008); CNA, *Framework for the Practice of Registered Nurses in Canada* (2015).

<sup>127</sup> For example, medical investigators and carers have died treating SARS, the Marburg virus, Ebola, and more: S LaFraniere and D Grady, 'Fear and Violence Accompany a Deadly Virus across Angola', *New York Times*, 9 April 2005, pp. 1 and 5; BBC News, 'Ebola crisis: Top Sierra Leone doctor dies from disease', *BBC News Online*, 19 December 2014, at <http://www.bbc.co.uk/news/world-africa-30553834> [accessed 30 April 2016].

patients. Because s 4(1) allows the exercise of *personal* rather than *professional* conscience, Montgomery claims as follows:

... [CO] as set out in s 4 of the Abortion Act 1967 needs to be understood as an act of heresy, a departure from the orthodox professional identity. It therefore needs to be justified by reference to the possibility of accommodating heterodox positions without undermining the identity of the profession.<sup>128</sup>

He goes on to argue that enabling professionals to shape the scope of access to abortion on personal moral grounds is unacceptable, in part because limiting that access undermines the public conscience of the professional as expressed in the various guiding instruments.<sup>129</sup>

With respect to exercising CO (and so departing from professional identity), the British Medical Association (BMA), a union which represents over 170,000 physicians, states that physicians should have a right to CO to participation in certain treatments, including abortion, but should not allow their religious or cultural beliefs to impact negatively on the doctor-patient relationship.<sup>130</sup> However, it notes that this right is not absolute and must not impact on the patient's right to care, and it cautions against discriminatory practices.<sup>131</sup> The GMC and the General Pharmaceutical Council (GPC) also allow CO, though both indicate that their members must inform employers, partners, colleagues, and relevant authorities about their views so that patient care is not compromised.<sup>132</sup> The Royal College of General Practitioners (RCGP) allows for wide-ranging opt-outs,<sup>133</sup> and it has been argued that there now exists a lack of clarity about which treatments healthcareers may validly opt out of using CO.<sup>134</sup>

The above suggests that healthcareers are expected to be reasonable and circumspect in their approach to CO too ready a reliance on it would undermine the values and standards which they are expected, as a self-regulating public-serving profession, to meet. Recognition of such would have been useful in *Doogan*; the UKSC might have stipulated that, while religious belief may well be a private matter, the exercise of CO in healthcare is not; it is a professional privilege that impacts on the timely availability of lawful treatments, and so its exercise is of great concern to the public.<sup>135</sup> It might have added that its invocation might therefore be limited to quite narrow circumstances, for healthcareers surely know (and accept) that they have an ethical duty to provide treatment that may not sit well with them (i.e., their sensibilities are often and rightly secondary to the needs of their patients).<sup>136</sup> Here, one might recall the admonition of Pope John Paul II:

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<sup>128</sup> Montgomery, note 23, at 211.

<sup>129</sup> Ibid, at 215. This is in keeping with jurisprudence that holds that police officers cannot refuse to carry out their professional lawful functions (i.e., defending an abortion clinic against a hostile anti-choice crowd) on the basis of personal convictions: *Rodriguez v Chicago* (1998) 156 F 3rd 771 (USCA 7th Circuit).

<sup>130</sup> BMA, *Conscientious Objection Guidance for Doctors and Medical Students*, at <http://www.bma.org.uk/support-at-work/ethics/expressions-of-doctors-beliefs>; BMA, *Expression of Doctors' Beliefs*, at <http://bma.org.uk/practical-support-at-work/ethics/expressions-of-doctors-beliefs> [both accessed 2 May 2016]. And see *Eweida and Others v UK* [2013] ECHR 37, and D Hill and D Whistler, *The Right to Wear Religious Symbols* (Palgrave, 2013).

<sup>131</sup> BMA, *ibid*.

<sup>132</sup> GMC, *Personal Beliefs and Medical Practice* (2013); GPC, *Guidance on the Provision of Pharmacy Services Affected by Religious and Moral Beliefs* (2010); GPC, *Standards of Conduct, Ethics and Performance* (2012).

<sup>133</sup> RCGP, *Good Medical Practice for General Practitioners* (2008).

<sup>134</sup> S Fovargue and M Neal, 'In Good Conscience: Conscience-Based Exemptions and Proper Medical Treatment' (2015) 23 Med Law Rev 221-241, at 227. Meaning that the lack of clarity around the scope of CO was not limited to its operation under the 1967 Act, and the UKSC might have addressed this at least in obiter.

<sup>135</sup> R Dresser, 'Professional Conformity and Conscience' (2005) 35 Hasting Centre Rep 9-10.

<sup>136</sup> So claimed by R Card, 'Conscientious Objection and Emergency Contraception' (2007) 7 Am J Bioethics 8-14, in relation to information and provision of emergency contraception.

... [F]reedom of conscience does not confer a right to indiscriminate recourse to conscientious objection. When an asserted freedom turns into a licence or becomes an excuse for limiting the rights of others, the State is obliged to protect, also by legal means, the inalienable rights of its citizens against such abuses.<sup>137</sup>

Ultimately, as a matter of professionalism, it is essential to ensure that CO does not become a barrier to accessing safe and effective reproductive health counselling, treatment (including abortion), and aftercare.

## V. Treatment and Objection: A Proper Balance

The above offered a rights-foundation for abortion and for CO, and a contextualising view of the healthcare profession, all of which supports a relatively limited availability of CO in the abortion (and other healthcare) context.<sup>138</sup> Had UKSC considered this foundation when interpreting the scope of s 4(1), it might have found as follows:

- By operation of the 1967 Act, abortion has been brought into the NHS system, which relies on healthcare teams providing treatment which is often (and in this case) viewed as a process involving a range of medical and non-medical actions and staff.
- CO is justifiably available to any of those individuals, but, bearing in mind the competing rights and the professional duties and identity implicated, the conditions for exercising CO are strict and the availability of its invocation is narrow.

The UKSC might then have articulated those conditions with respect to the 1967 Act and beyond, and offered some insight into the range of measures that might be adopted (by health authorities) to ensure timely access to abortion treatment and the appropriate exercise of CO (so that all UK stakeholders might be unquestionably aware of their responsibilities when it comes to abortion services and the scope of CO in relation thereto). The measures that might be adopted to ensure access to abortion and justifiable use of CO implicate training, healthcare administration, and personal action.

With respect to training and administration, the government and health authorities might have been encouraged to scrutinise and work with medical and healthcare educators to ensure that they are training sufficient numbers of healthcarers to provide quality reproduction services. Related to this, medical schools, health authorities and hospital administrators might have been reminded that they need to ensure that NHS and hospital management policies are such that sufficient numbers of healthcarers trained and prepared to undertake a full range of care, including abortions, are on staff.<sup>139</sup> They must also ensure that a sufficient number and spread of hospitals

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<sup>137</sup> Pope John Paul II, *If You Want Peace, Respect the Conscience of Every Person*, Message for the 24th World Day of Peace, Vatican City, 1991, para. 24.

<sup>138</sup> Which can be differentiated from contexts such as military service or participation in armed conflict. CO to military service could be broader and more readily available because the geopolitics which militaries support is rarely morally sound (often more about economics than human wellbeing), and war-making is often a terrible burden to individuals, to societies, and to the environment, as well as to budgets and economies. Healthcare interventions, however, and specifically abortions, preserve and/or restore individual physical and emotional wellbeing and life opportunities at the expense only of an entity of contested status.

<sup>139</sup> In this regard, note *Judgment 12/13/1991*, BVerwGE 89, 260-70 (FRG), wherein the Federal Administrative Court of Germany affirmed a decision of the Bavarian High Administrative Court holding that a municipality's job posting for a physician in a women's hospital could lawfully include a requirement that he or she be willing to perform abortions.

with quality abortion services exists, and that clinics are appropriately folded into the healthcare architecture. Related to this, it might have been strongly emphasised that institutions cannot invoke CO, and must not contractually limit their employees from participating in reproductive healthcare, including abortion.

With respect to training and personal action, the UKSC might have noted that medical schools and health authorities need to ensure that medical and healthcare education equips practitioners to comprehend the basis of the abortion debate from multiple perspectives (i.e., their profession, society, and individual women affected).<sup>140</sup> This will not only allow healthcarers to think proactively about their own values and duties, but also to fashion comprehensible COs when they have them and to evaluate COs that have been made. With respect to shaping personal action, the UKSC might have encouraged health authorities to ensure that clear policies and mechanisms for the exercise of CO are in place.<sup>141</sup> Fovargue and Neal offer a defensible list:<sup>142</sup>

1. A CO can be invoked in response only to those treatments whose status as 'proper medical treatment' is contested or liminal.<sup>143</sup>
2. When invoked, CO must meet certain criteria to wit the position held must be:
  - a. sincere;
  - b. tolerable and respectful of the conscientious conclusions of others;
  - c. capable of articulation and externalisation; and
  - d. fundamental such that its violation poses a serious risk to one's moral integrity.
3. As a condition of exercise, CO must be contingent upon satisfying duties to:
  - a. behave respectfully, sensitively, empathically, and non-confrontationally to the (possibly vulnerable) patient;<sup>144</sup>
  - b. avoid imposing unnecessary or unreasonable burdens on patients and colleagues;
  - c. act despite one's CO in emergency situations;
  - d. account if called upon to do so; and
  - e. immediately refer the patient to another physician within the institution or as close as possible so that the treatment can be obtained.<sup>145</sup>

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<sup>140</sup> K Jones and C Chaloner, 'Ethics of Abortion: The Arguments For and Against' (2007) 21 Nursing Standard 45-48.

<sup>141</sup> And the importance of standards and SOPs has been recognised: PACE, *Resolution 1763 (2010): The Right to Conscientious Objection in Lawful Medical Care*, 35th Sitting of the Assembly, 7 October 2010. This Resolution started out as *Women's Access to Lawful Medical Care: The Problem of Unregulated Conscientious Objection*, but a campaign by anti-choice Assembly Members and NGOs resulted in a reversal of its thrust: Agenda Europe Blog, at <https://agendaeurope.wordpress.com/council-of-europe/parliamentary-assembly-pace/> [accessed 2 May 2016]; C Zampas and X Andión-Ibanez, 'Conscientious Objection to Sexual and Reproductive Health Services: International human Rights Standards and European Law and Practice' (2012) 19 Euro J Health Law 231-256. As it stands, the Resolution recommends that patients be informed of any objection in a timely manner, that referrals to another healthcarer be provided, and that patients receive appropriate treatment, especially in cases of emergency.

<sup>142</sup> Fovargue and Neal, note 134, at 227-238.

<sup>143</sup> A condition which undermines its availability in the abortion context given the clear harms that can result from an absence of access to reproductive treatments, including abortion, and the position of the international human rights community noted above. In short, it is difficult to argue that the position of abortion as a proper medical treatment is in some way 'liminal'.

<sup>144</sup> M Magelssen, 'When Should Conscientious Objection Be Accepted?' (2012) 38 J Med Ethics 18-21.

<sup>145</sup> This, it has been argued, is an essential element of ethical care: B Dickens, 'Conscientious Objection: A Shield or a Sword?' in S McLean (ed.), *First Do No Harm: Law, Ethics and Healthcare* (Ashgate, 2006) 327-351; B Dickens, 'Legal Protection and Limits of Conscientious Objection: When Conscientious Objection is Unethical' (2009) 28 Medicine & Law 337-347.

A few words on criterion 2.c. and duty 3.d. is warranted. The criterion suggests a need for objector to articulate and make public (at least to some extent) the CO. While the details would certainly be left to the employer, it has been argued that COs should be made in writing, which form must advance a sensible position rationally connected to one's moral integrity, and which form must additionally be reviewed.<sup>146</sup> Given the ideological positions that have occupied abortion politics, some form of review seems appropriate.

On the matter of criteria and duties, the UKSC might have profitably noticed a number of significant authorities and precedents. For example, the WHO has stated the following:

Health-carers who [CO] must refer the woman to another willing and trained provider in the same, or another easily accessible healthcare facility. Where referral is not possible, the health-care professional who objects must provide abortion to save the woman's life or to prevent damage to her health. Health services should be organised in such a way as to ensure that an effective exercise of the freedom of conscience ... does not prevent patients from obtaining access to services to which they are entitled.<sup>147</sup>

From a jurisprudential perspective, *Decision T-388/2009* of the Colombian Constitutional Court is on point.<sup>148</sup> In that case a 13 year-old girl was raped, became pregnant, and sought an abortion pursuant to the requirements set out in *Decision C-355/2006*.<sup>149</sup> However, she was bounced around between several health facilities, who gave her bad information, and she was, in the end, forced to give birth. In a much more engaged and satisfying decision, the Court firmly and usefully grounded its judgment on the fact that Colombia – like the UK – is a participatory and pluralistic democracy that must respect human dignity.<sup>150</sup> Thus, while the exercise of a liberty such as CO is warranted, it must not, even inadvertently, result in an arbitrary or disproportionate interference with the rights of others.<sup>151</sup> The Court stated that limitations on CO are justified when it is raised in the context of legitimate and lawful procedures, and it went on to stipulate as follows:

- CO can only be exercised by an individual with direct participation in the procedure (e.g., surgical nurses, surgeons, anaesthetists, not admitting staff, post-operative nurses, office personnel, ambulance attendants, dispensing pharmacists, etc.).<sup>152</sup>

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<sup>146</sup> Council of Europe, *Recommendation No. R(87)8 Regarding Conscientious Objection to Compulsory Military Service*, adopted by the Committee of Ministers on 9 April 1987 at the 406th meeting of the Ministers' Deputies. See C Meyers and R Woods, 'An Obligation to Provide Abortion Services: What Happens When Physicians Refuse?' (1996) 22 J Med Ethics 115-120; L Kantymir and C McLeod, 'Justification for Conscience Exemptions in Health Care' (2014) 28 Bioethics 16-23.

<sup>147</sup> WHO, *Safe Abortion: Technical and Policy Guidance for Health Systems*, 2nd ed. (2012), at 96. See also WHO, *Complications of Abortion: Technical and Managerial Guidelines for Prevention and Treatment* (1995), which recognises that a properly functioning referral system is essential for realising women's reproductive rights.

<sup>148</sup> *Decision T-388/2009*, Gaceta de la Corte Constitucional, 28 May 2010 (Col Cst Ct), which determined the scope of a practitioner's right to invoke CO in relation to abortion, in this case a judicial officer.

<sup>149</sup> *Decision C-355/2006* (Col Cst Ct) determined the conditions under which an abortion might be induced.

<sup>150</sup> *T-388/2009*, sec. 5.1.

<sup>151</sup> A position which reflects that adopted by the ECtHR to the effect that, in a pluralistic society, not every religious belief or practice will justify CO: M Campbell, 'Conscientious Objection, Health Care and Article 9 of the European Convention of Human Rights' (2011) 11 Med Law Int 284-304.

<sup>152</sup> *T-388/2009*, sec. 5.1.



- The healthcare provider must state his objection in writing, indicating reasons, and with reference to the facts of the case, but without general language offered by other institutions such as religious authorities, and objections must be reviewed by another medical professional or government committee (to test for religious or moral foundation, consistency, etc.).<sup>153</sup>
- The healthcare provider must refer the patient to a willing colleague, and hospitals can recover liability costs from physicians who fail to meet their obligations to refer.<sup>154</sup>
- The healthcare service must ensure the presence of a sufficient number of healthcare providers to protect the rights of women to medically indicated abortions.<sup>155</sup>
- Institutions such as health facilities cannot exercise the right of CO because they are not natural persons with a conscience or soul, nor can institutions enter into agreements to refuse to provide abortions, nor direct their physicians to refuse to perform abortions.<sup>156</sup>

Obviously, the UKSC cannot impose all of the above obligations on all of the relevant actors (in all of the potential CO scenarios) in the context of a single case. But highlighting them in *Doogan* would have been salutary; it would have brought the significance of the precedent more in line with the more comprehensive and socially situated *Decision T-388/2009*, which is much celebrated,<sup>157</sup> and it would have made the decision more relevant beyond the facts of this case, an outcome to which the UKSC should aspire.

## VI. Conclusion

Access to safe and legal abortion, where it has been achieved, is under threat, not least from healthcare providers who would decline to advise patients about, or to perform, abortions based on their religious or ideological beliefs. Given the growing prevalence of questionable deployments of CO, a robust discussion of its foundation and limits is warranted so that it is clear to all interested parties that the right of CO is grounded in the human right of freedom of conscience and religion, that its use by healthcare providers is justified, *but* that the right of CO is subject to limits, and that the restrictions on its use are properly broad and strictly enforced in the abortion context because of what is at stake, namely the physical and emotional wellbeing of women (and families) and their right, long undermined, to dignity and autonomy in reproductive health. Other supreme courts have offered much more holistic examinations of CO and its proper limits, and so have better reminded healthcare providers and other public officials that they must respect the conscience of the women to whom they owe duties of care. *Doogan* could and should have been an equally holistic examination, affirming the obligation to use CO sparingly, and with clear and rational justifications and supported by acceptably moral behaviour, but it was not. The UKSC's failure to grasp the nettle of CO in its broader context must be seen as a lost opportunity to provide much-needed clarity in the care-giving landscape. Perhaps next time.

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<sup>153</sup> *T-388/2009*, sec. 5.1. For more on this, see L Cabal, M Arango Olaya, V Montoya Robledo, 'Striking a Balance: Conscientious Objection and Reproductive Health Care from the Colombian Perspective' (2014) 16 *Health & Human Rights* E73-83.

<sup>154</sup> *T-388/2009*, sec. 5.1.

<sup>155</sup> *T-388/2009*, sec. 5.1.

<sup>156</sup> *T-388/2009*, sec. 5.1.

<sup>157</sup> Women's Link Worldwide, *T-388/2009 Conscientious Objection and Abortion: A Global Perspective on the Colombian Experience* (O'Neill Institute, 2014).